Act 2014-172

Compliance Process for Currently Licensed Out of State Providers of Home Medical Equipment

General Statement:

Act 2014-172 becomes effective on June 1, 2014, and requires all Alabama Home Medical Equipment Licensees to have a physical location within Alabama that meets the Board's licensure requirements, including compliance with the Medicare DMEPOS Supplier Standards and passage of an onsite inspection. Currently licensed out of state providers will have until the expiration of their licenses on August 31, 2014, to demonstrate compliance with the new location requirement. Below is the specific statute pertaining to this new requirement:

> **"Section 34-14C-4 (a)** Except as otherwise provided in this chapter, a home medical equipment services provider shall be licensed annually by the board before the provider may engage in the provision of home medical equipment services from more than one location within the state, each such location shall be licensed. **A provider of home medical equipment services that has a principal place of business outside this state shall maintain at least one physical location within this state, each of which shall be licensed."**

Out of State Providers will not have to reapply for licensure or pay the $500 Site Inspection Fee for new licensees. However, in order for out of state providers to maintain licensure in Alabama, the following items must be completed:

- Establish an in state location that meets the Medicare DMEPOS Supplier Standards
- Submit an Application for Change of Address including $275 Site Inspection Fee
- Pass a Site Inspection

Note: For a new location, many providers will also need to submit an Application for Change of Person In Charge for that location. There is no fee for this change and a new application will not have to be submitted.

For your convenience, please find attached the following items:

- Application for Change of Address
- Application for Change of Person in Charge
- Medicare DMEPOS Supplier Standards and Site Inspection Form

If you have any questions related to the new licensure requirements or the submission of your application(s) to the Board, please contact us at 334.215.3474.

Alabama Board of Home Medical Equipment Services Providers
P. O. Box 240636, Montgomery, AL 36124
Phone: 334-215-3474 FAX: 334.215.3457
Web Site: **www.homemed.alabama.gov**

APPLICATION FOR CHANGE OF ADDRESS

Instructions:

- **This form is to be completed for existing licensees who are requesting a change of address only.**
- **If additional changes such as equipment provided, FEIN or SSN, or disciplinary actions have ensued,**

here. You will need to complete a new application instead.

- **Once this completed form is received in the Board Office, you will be contacted by an Inspector for the Board to schedule your site inspection. The site inspection form and 21 Supplier Standards are published at www.homemed.alabama.gov for your convenience.**

Current License Number: _____

Applicant Information

(Instructions: Please list below the new address and information)

Legal Business Name: _____
(D.B.A., Trade, or Business Name)
Street Address: _____

City, State, Zip Code: _____

Phone: (____)_____ FAX: (____)_____

E-mail Address: _____

Preferred Mailing Address (for mailing purposes only):

_____

City, State, Zip Code: _____

FEIN# or SS#: _____ Date Business Started: __/__/____

☐ Yes ☐ No Are patient records stored at this location?

If "No", where are they kept?

_____

_____

_____

_____

Instructions: All business licenses and occupational licenses are required to reflect the new physical address. List all business and occupational licenses you hold below (i.e. city, county or state business license, pharmacy license if supplying oxygen, Elevator Permit if supplying stair lifts, Orthotics and Prosthetics License (if supplying custom made O & P):

State/County/City	Type License	Date License Expires	Is the new address reflected on this license?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

If additional space is needed, record on a separate sheet of paper and attach to this application.

General Liability Insurance

Instructions: General Liability Insurance Policy must reflect the new physical address.

Insurance Company Name: _____

Policy Number: _____ Date Issued: _____

Expiration Date: _____ Agent Name: _____

Agent Phone #: _____ Agent FAX: _____

- □ I have attached a copy of all business and occupational licenses reflecting new address;
- □ I have attached a copy of certificate of coverage for general liability insurance (minimum of $300,000) reflecting new address;
- □ I have attached $275 for the Site Inspection Fee upon Change of Physical location.
- □ Location is ready for site inspection now
  OR
  Location will be ready for site inspection after ___/___/_____.
  (licensees are to file a change of address notice 30 days prior or 30 days after move.)

Affidavit of Applicant

I, _____ acknowledge and state that all of the information supplied in this application is true and correct to the best of my knowledge, and that I have read and are familiar with the Rules and Regulations pertaining to the licensure of Home Medical Equipment Services Providers in the State of Alabama. I acknowledge that any false or untrue statements or representation made in this application may result in the revocation or denial of any license to provide home medical equipment granted to me and/or criminal prosecution to the fullest extent of the law.

_____ _____

Person in Charge Signature Date

MEDICARE SUPPLI ER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.

2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.

4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non·procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment

6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business, with visible signage. The location must be at least 200 square feet and contain space for storing records.

8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.

9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own

items, this insurance must also cover product liability and completed operations.

11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

13. A supplier m11st answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts. 14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to

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beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare · covered item.

17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.

18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS · approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
Impl€11lentation Date- October I, 2009

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date May 4, 2009*

27. A supplier must obtain oxygen from a state licensed oxygen supplier.

28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516 (f).

29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.

30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

P.O. Box 240636; Montgomery, AL 36124
Web Site: www.homemed.alabama.gov

SITE INSPECTION RESULT FORM (Copy to be left with Interviewee) Date: _____

Company Information:

Name: _____ **Phone #:** _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

_____ _____
Inspector Printed Name Signature of Inspector

_____ _____
Interviewee Printed Name Signature of Interviewee

Results:

□ Yes □ No Site Inspection Completed? If unable to conduct site visit for any reason, explain below: _____
□ Yes □ No Site passes inspection? If No, please circle the corresponding number below:

1. Not appropriate location: _____
2. Not handicapped accessible: _____
3. Not a visible sign on the front of the facility: _____
   Sign does not have required information: _____
4. Hours of operation are not posted or are different than hours listed on application: _____
   Emergency information is not posted: _____
5. a. Patient records are not maintained at facility or appropriate off-site facility: _____
   b. Records do not include supplier delivery slips _____
   c. Records do not include supplier maintenance records _____
   d. Records do not include beneficiary communications including complaint and education records: _____
6. a. Business phone number is not listed in local directory: _____
   b. Other number for beneficiaries is not appropriate: _____
   c. Emergency number is not appropriate: _____
   d. Answering Service not provided or does not meet requirements: _____
7. a. Occupational License not found or expired: _____
   b. State Business license not found or expired: _____
   c. City or County Business License not found or expired: _____
   d. General Liability not found, not enough coverage, or expired: _____
   e. Oxygen Permit not found or expired: _____
   f. Elevator Permit not found or expired: _____
   g. Orthotics & Prosthetics Permit not found or expired: _____
   h. Other: _____
8. a. PIC, Owner, President, Mngr. Administrator not available for Interview: _____
9. Supplies provided at location do not match the items listed on application: _____
10. a. Inventory is stored inappropriately: _____
    b. Inventory is not in stock and no contract or credit agreement is in place: _____
11. Copy of Supplier Standards is not provided to Medicare Beneficiaries: _____
12. Supplier Stickers are not placed on equipment with appropriate information: _____

Additional Notes: _____

□ If Site Inspection is Failed: Licensees who fail to pass an inspection must cease and desist their operations upon receipt of a copy of this Site Inspection Results Form until they have come into compliance with all applicable standards, unless the Board negotiates a written plan for compliance with the licensee and conducts a further inspection for compliance at a time to be determined by the Board. Upon notice of a failure to pass inspection and obtain a license, **licensees and applicants** have 30 days to file a written appeal regarding the site inspection results and/or request a new inspection (following resolution of the cited deficiencies) or be subject to the penalties provided under Ala. Code § 34-14C-6. Submit all such requests to the Board office on company letterhead and include a $150.00 re-inspection fee.

□ Upon passing the site inspection: Applicants who have passed the site inspection have 60 days from the date of written notification of approval to submit the $250.00 license fee, or the application and fees will be forfeited. Your license will be issued upon receipt of the licensure fee. **The Fee Schedule is located under the Rules and Regulations at www.homemed.alabama.gov. Supplier Standards are also available on this site.**

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P. O. Box 240636, Montgomery, AL 36124
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APPLICATION FOR CHANGE OF PERSON IN CHARGE

Instructions:

- **This form is to be completed for existing licensees who are requesting a change of Person in Charge only.**
- **If additional changes such as equipment provided, FEIN or SSN, or disciplinary actions have ensued,**

here. You will need to complete a new application instead.

- **No fee is required for only a change of Person in Charge.**

Current License Number: _____

Applicant Information (Applicant means an individual applicant in the case of sole proprietorship, or any officer, director, agent, managing employee, general manager, or person in charge, or any partner or shareholder having an ownership interest in the corporation, partnership, or other business entity. **For each entity/person with any ownership interest in applicant, copy this page and complete in its entirety for each individual.**

Legal Business Name: _____

D/B/A name: _____

Your Name: _____ Title: _____

☐ check this box if this individual is to be designated as the Person in Charge on the license

Home Address: _____

City, State, Zip Code: _____

Home Phone #: (____)_____ SSN: _____

Date of Birth: ____/____/_____ Birth State: _____ Birth County: _____

Parent/Home Office Information (If applicable)

Name: _____

CEO: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____ FAX #: _____

E-Mail: _____ FEIN#: _____

Your Affiliation: ☐ Joint Venture/Partnership ☐ Wholly Owned
☐ Managed ☐ Subsidiary
☐ Operated ☐ Leased
☐ Other: _____

Check if this entity/owner has EVER had any of the following adverse actions imposed by the Medicare, Medicaid, or any other federal agency program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copies of adverse legal action notification.

☐ **Administrative Sanctions(s) ___/___/_____** ☐ **Criminal Fines ___/___/_____**
☐ **Program Exclusion(s) ___/___/_____** ☐ **Restitution Order(s) ___/___/_____**
☐ **Suspension of Payment(s) ___/___/_____** ☐ **Pending Civil Judgments(s) ___/___/_____**
☐ **Civil Monetary Penalty(s) ___/___/_____** ☐ **Pending Criminal Judgments(s)___/___/___**
☐ **Assessment(s) ___/___/_____** ☐ **Judgments(s) Pending False**
☐ **None of These** **Claims Act ___/___/_____**

Does this entity/owner have any outstanding criminal fines? ☐ Yes ☐ No
Does this entity/owner have any outstanding restitution orders? ☐ Yes ☐ No
Has this entity/owner ever been convicted of any health care related crimes? ☐ Yes ☐ No
Has this entity/owner ever been convicted of a felony under Federal or State law? ☐ Yes ☐ No
Are you a citizen of the US? ☐ Yes ☐ No

Statement to the Board

Administrative Code of Alabama CHAPTER 473-X-1-(1) Applicant means an individual applicant in the case of a sole proprietorship, or any officer, director, agent, managing employee, general manager, or person in charge, or any partner or shareholder having an ownership interest in the corporation, partnership, or other business entity.

I, _____ being first duly sworn declare under penalty of perjury as follows:

I am the applicant described and identified in this application for licensure in the State of Alabama.

To the best of my knowledge, the information contained in this application and its supporting document(s) is truthful, correct, and complete; and discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Board in conjunction with this application or its supporting documents meets the same standards as set forth above.

I understand that it is unlawful and punishable as a Class A misdemeanor to apply for or obtain a license or otherwise deal with the Board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for the inspection by the public, except with regard to the release of information which is classified as controller, private, or protected under the Government Records Access and Management Act or restricted by other law.

Has the applicant ever been convicted of any health related crime?
☐ Yes ☐ No
Has the applicant ever been convicted of a felony under Federal or State Law?
☐ Yes ☐ No
Has any family or household member of the applicant ever been convicted, assessed, or excluded from the Medicare or Medicaid program due to fraud, obstruction or an investigation, filing of false claims, or providing false information? ☐ Yes ☐ No

I, _____ being duly sworn, depose and say I certify that I have read, understand, meet, and will continue to meet all supplier standards outlined in 42CFRG424.57 and comply with the Rules and Regulations of the Alabama Board of Home Medical Equipment Services Providers and have truthfully and completely disclosed all ownership and control of the applicant, and that all information submitted on/or with this application is true and complete.

I hereby authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Board, records or information required for the Board to properly evaluate my qualifications for licensure by the State of Alabama.

_____ _____

Signature of Applicant Date of Signature

Subscribed and Sworn to before me this _____ day of _____, 20_____.

_____ _____

Signature of Notary Public Printed Name of Notary Public

(SEAL)

_____

My Commission Expires

Alabama Board of Home Medical Equipment Services Providers
Proof of Citizenship (POC) Form – for Initial HME License

Instructions:

- This form is to be completed by applicants for licensure in order to comply with Ala. Code § 31-13-7 (1975 as amended).
- This form must be completed by each individual affiliated with the ownership of the company and by the applicant (if other than an owner of the company). Copies of this form may be made as needed.
- Please mail this completed form with a **copy** of the required documentation proving citizenship or legal presence to: The Alabama Board of Home Medical Equipment Services Providers, P.O. Box 240636, Montgomery, AL 36124-0636. **Do not send originals or faxes of citizenship/legal presence documents.**

Name (Please Print): _____ Permit #: _____

Company Name: _____

Track I: Please complete this section if you are a United States Citizen. Check all that apply below:

- o I am a United States Citizen. I am submitting the attached COPY of my document to prove citizenship:

Please check and submit one of the following:

- o Alabama Driver's License or Identification issued by the Department of Public Safety
- o Driver's License from other state that required proof of lawful presence
- o Birth Certificate indicating U.S. Birth
- o Valid U.S. Passport
- o Military Identification showing U.S. as place of Birth
- o Naturalization documents
- o Certificate of Citizenship
- o Consular report of birth abroad of U.S. Citizen
- o Bureau of Indian Affairs Identification
- o American Indian Card issued by Homeland Security
- o Final adoption decree showing person's name and place of U.S. Birth
- o A valid Uniformed Services Privileges and Identification Card
- o Extract from a United States hospital record of birth created at the time of the person's birth indicating the place of birth in the United States.
- o Certification of Birth Issued by U.S. Department of State

I hereby declare that I am a citizen of the United States of America. I sign this declaration under penalty of perjury; making a false or fictitious statement or representation in this declaration is perjury in the second degree, pursuant to Ala. Code § 13A-10-102.

_____ _____
Signature Date

Track II: Please complete this section if you are not a United States Citizen. Check all that apply below:

- o I am not a United States Citizen. I am submitting the attached COPY of my document to prove legal presence in the United States:

Please check and submit one of the following:

- o I-327 Re-entry Permit
- o I-551 Permanent Resident Card
- o I-571 Refugee Travel Document
- o I-766 Employment Authorization Card
- o I-94 Arrival/Departure Record
- o Unexpired Foreign Passport
- o Temporary I-551 Stamp (on passport or I-94)
- o I-20 Certificate of Eligibility for non-immigrant (F-1) student status
- o DS 2019 Certificate of Eligibility for Exchange Visitor (J-1) status
- o Machine-readable immigrant Visa (with temporary I-551 language)
- o Other: Explain: _____

I hereby declare that I am an alien lawfully present in the United States of America. I sign this declaration under penalty of perjury; making a false or fictitious statement or representation in this declaration is perjury in the second degree, pursuant to Ala. Code § 13A-10-102.

_____ _____
Signature Date